STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Country Club Hill	18200 South Cicero Avenue Country Club Hills, IL 60478

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary assistance for one dependent resident (R149) in accordance with care plan by failing to complete weekly shower/skin assessment as ordered. This failure affected one (R149) of six residents reviewed for Activities of Daily Living (ADL) care. R149 developed a hematoma to her right great toe at the facility, complaint of pain where it was noted R149's wound was infected, and an x-ray revealed a fracture to the right great toe. R149 was treated with oral antibiotics for seven days.Findings include:R149 is a [AGE] year-old female who has resided at the facility since 8/28/2025, past medical history includes, but not limited to hypertensive heart disease, other dysphagia, other reduced mobility, type 2 diabetes, anemia, hemiplegia, and hemiparesis following cerebral infarction affecting the right dominant side, etc.On 11/17/2025 at 10:30AM, R149 was in her bed, awake and alert but could not answer any questions, resident was able to nod yes and no to some questions. The nurse was outside the door preparing medication for resident, surveyor requested her assistance to assess resident's right great toe, which was noted with no dressing, dry and with some whitish discoloration close to the nail bed. Surveyor asked resident if she still gets dressing to her toe and she shook her head no.Wound care note dated 10/1/2025 documented a facility acquired hematoma to right great toe measuring 2.50 X 2.0 X unknown (L X W X D). Area 5.00cm, volume unknown. Tissue type- blood filled blisters 100%.R149 was assessed as being dependent on staff for all activities of daily living (ADL) needs and always incontinent of bowel and bladder, Behavior assessment indicated that resident does not exhibit any behaviors. Active physician order documented the following: Right great toe: cleanse with normal saline, pat dry and paint with betadine and cover with dry dressing daily and as needed for wound care. Weekly showers/skin assessment, acknowledgement of shower and skin assessment completed. If new skin issue, notify physician, notify family and complete skin assessment form.Care plan initiated 10/1/2025 documented that resident has arterial wound to right great toe, is at risk for delayed wound healing and is at risk for further alteration in skin integrity related to anemia, diabetes, hypertension, and peripheral arterial disease. Interventions include monitor skin during care and report changes, ongoing assessment of wound to evaluate signs of deterioration or improvement, treatment as ordered by physician, etc.Urgent care record dated 10/25/2025, history of present illness documented in part: [AGE] year-old female parented(sic) with right great toe injury discovered 25 days ago by family when they removed resident's socks. Currently patient reports pain to right great toe at the site of injury, pain is worse with touch.X-ray of foot 3 or more view indicated under impression of acute nondisplaced intra- articular fracture of the distal phalanx of the right toe.Diagnosis was listed as cellulitis of right toe, nondisplaced fracture of distal phalanx of right toe, type 2 diabetes. Medication orders: prescribed clindamycin HCL300mg capsule, take 1 capsule by mouth every 6 hours for seven days.Shower sheets for the months of September, October and November indicated that R149 was not receiving showers as scheduled, occasional bed baths, no documented skin assessment and marked mostly as refused.On 11/19/2025 at 12:59PM, V49, Certified Nursing Assistant (CNA) said that she does not have any issues with resident, she works with her on day shift and always assist her with dressing up and brushing her teeth. Resident is (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	usually set up in the bathroom by the sink, and she brushes her teeth by herself. Resident does not refuse ADL care as far as V49 is concerned, she is always pleasant.On 11/18/2025 at 3:05PM, V24 (Wound Care Coordinator) said, nurses are supposed to sign off the skin assessment section of the shower sheet after the CNA finishes the shower if the resident lets them. V24 was asked if the nurses should document resident's refusal in the progress note and she said that she is not sure, that will be the question for the nurses. On 11/19/2025 at 2:15PM, V24 was asked about R149 wound to her great toe. V24 said, resident was being treated with betadine and the wound was being assessed daily by wound care, and they did not notice any signs of infection. V24 added that she was not aware that resident's toe was infected, nor aware of the antibiotic treatment or that she had a fracture.On 11/19/2025 at 9:05AM, V2, Director of Nursing (DON) said, resident had a bump on her toe which started after family gave her a shower and told staff that they accidentally bumped resident's toe on her wheelchair. V2 said that the wound care doctor saw the resident and she was getting treatment for it. V2 added that R149 always refuse ADL care. Surveyor asked V2 if that was care planned and she said that she was not sure. On 10/25/2025, resident's daughter came in, showered the resident, and dressed the resident herself, took the resident out on pass without informing anyone in the facility. While on pass, the daughter took resident to urgent care and they prescribed antibiotics for her, they also did an x-ray that showed a fracture to her right great toe, V2 does not know that resident's toe was infected, or how resident got the fracture.On 11/10/2025 at 12:15PM, V1 (Administrator) said that she investigated and reported resident's injury as an injury of unknown origin, but it was not unsubstantiated because resident did not complain of pain before the family took her out on pass. The injury started as a redness which occurred after family gave resident a shower and accidentally bumped her feet on her wheelchair V1 said that the family reported the incident to the nurse. On 11/19/2025 at 12:02PM, V51 (LPN) said that she worked 3 to 11pm shift on 10/25/2025, R149 was out on pass at the beginning of her shift. The daughter came to the nursing station later that evening and handed her a bottle of medication, stating that R149 has an infection to her toe and also has a fracture.V51 said that family usually gives resident a shower and one day, the daughter told V51 that she accidentally bumped resident's toe on her wheelchair, that's how she got the injury. Surveyor asked V51 if she documented the reported incident by the family and she said no. V51 then changed her story stating that the family did not report that to her, but she just assumed that since they always give her a shower, that must have been the cause of the injury. V51 added that she is not sure how the resident sustained the fracture and was not aware that her toe was infected until the daughter came back from urgent care with the antibiotic.Bathing-shower and tub bath policy dated 1/31/2018 documented its purpose as to ensure resident's cleanliness to maintain proper hygiene and dignity. Guideline- a shower, tub bath or bed/ sponge bath will be offered according to resident's preference two times per week, or according to resident's preferred frequency and as needed or requested. Document bathing and assistance provided in the electronic health record, including pertinent observations.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer medication as ordered for one resident (R77) reviewed for medication administration. This failure affected one resident and has the potential to affect all residents residing on the 2nd floor.Finding includes:R77's medical record Admissions Record showed documentation that R77 was originally admitted on [DATE] and current admission date is 10/29/2025. Listed diagnosis include but not limited to Acute and Chronic Respiratory failure with hypoxia, metabolic Encephalopathy, encounter with Hospice care, other reduced mobility, other specified disorders of muscle, pressure induced deep tissue damage of sacral region, pressure induced deep tissue damage of other sites, presence of pacemaker, unspecified atrial fibrillation, and type 2 diabetes mellitus with diabetic neuropathy.R77 physician Order Summary Report showed that R77 has an order dated 11/13/2025 for Ativan oral tablet 0.5mg (Lorazepam) with instruction to give 0.5mg tablet by mouth every 6 hours for anxiety, agitation: give 2 tabs (tablets).R77's MAR (Medication administration Record) dated 11/1/25 to 11/30/2025 showed the same and instruction.R77's Controlled Drug Receipt/record/Disposition Form presented showed that on 11/14/25 R77 was administered two tablets of lorazepam tablet 0.5mg to equal 1mg and from 11/14/25 from 6pm only one tablet was administered instead of two tablets as ordered until 11/18/25 at 12 noon.R77' s MAR (Medication Administration Record) showed that the medication was signed out as if two tablets of lorazepam 0.5mg had been administered as ordered.On 11/18/2025 at 11:49am, V43, LPN (Licensed Practical Nurse) stated, we told (V2 (Director of Nursing) about it as you were looking at the narcotic book. I don't know why others (nurses) are giving him one tablet (referring to Ativan 0.5mg) because the order was to give 2 tablets to make it 1mg. Surveyor asked V43 can the nurses decrease or increase medication dosage without a physician order. V43 stated, No, the doctor must order it. At approximately 12:20pm, V43 administered 2 tablets of Ativan 0.5mg to R77 for anxiety as ordered. V43 stated (R77) Ativan has been changed from Ativan 0.5mg to Ativan 1mg. We (Licensed Nurses) are to give 2 tablets of 0.5mg to make it (equal) 1mg. V43 stated, medications are supposed to be signed out as administered to show the dose given and it should be signed out after the patient has taken the medicine.On 11/18/2025 at approximately 2:09pm, V2 (DON) stated, medications should be given as ordered by the physician or the NP (Nurse Practitioner.) V2 stated, R77's order for Ativan was changed on 11/13/2025 from 0.5mg to 1mg but for some reason the nurses are not giving R77 two (2) tablets of the 0.5mg as ordered and instructed. V2 stated, it is written in the MAR and the medication card and that is an error on the nurse's part.The facility policy on Physician Orders with revision date 1/31/18 documented that the purpose is to provide general guidelines when receiving, entering, and confirming physician or prescriber's orders (a prescriber is noted as physician, nurse practitioner, and a physician's assistant).Listed guidelines includes entering the order in the resident's chart, medication orders should include but not limited dose, time and frequency. Verbal and telephone orders will be documented as such in the electronic medical record.Facility Medication Administration policy presented with revised date1/1/2015 documented that medications must be administered in accordance with a physician's order that includes but not limited to right dosage, and right medication. Under the title Medication treatment errors documented in part that if a medication error occurs, this, the licensed nurse will immediately notify the attending physician, describe the error and resident response, identify the error on the 24-hour report. The policies documented that any discrepancy must be reported immediately to the Director of Nursing or his or her designee.